Adult Foster Care and Supported Living Services for Adults Provider Self-Assessment

Instructions

You must submit a separate assessment for each home in which adult foster care and/or supported living services are provided.

Staff with personal knowledge of the Foster Care or SLS home must provide the information.

Submit all provider self-assessments electronically on or before **May 29, 2015**.

Additional instructions are available.

Responses should be as accurate as possible. Immediate compliance with the new federal requirements is not required. The state will offer a transition period for providers who are not yet, but intend to, comply with the new requirements.

Purpose of provider self-assessment

The Centers for Medicare and Medicaid (CMS) issued a new rule governing HCBS waiver services effective March 17, 2014. The rule defines settings in which HCBS services may be delivered, settings that are not HCBS and settings that are presumed not to be HCBS. Minnesota submitted a transition plan to CMS indicating how it will come into compliance with the new rule.

The rule and transition plan require Minnesota to complete an assessment of all provider owned and controlled settings to determine their level of compliance with the new requirements. CMS requires states to follow-up with on-site monitoring and to assure on-going compliance. Completion of this provider self- assessment is the first step in the process.

The provider self-assessment is designed to:

1. Provide the state with information that will be used to develop measurable criteria for HCBS services in the future.
2. Identify sites that are not in currently in compliance with the rule.
3. Identify settings that are presumed not to be HCBS.
4. Help providers understand changes needed to comply with the rule.

Definitions for purposes of this assessment

CSSP addendum: Plans that providers develop as required in Minnesota Statute chapter 245D.

Home: refers to the home licensed as adult foster care or community residential setting.

Person: Refers to the individual receiving services.

Plan: Refers to plans developed by the lead agency certified assessor or case manager (i.e. CSP, CSSP, ISP).

Navigation

A toolbar at the bottom of each page will help you as you complete the assessment.

1. Please disable any pop-up blockers when completing this assessment.

2. To move between pages, use the BACK and NEXT buttons at the bottom of each page. DO NOT USE THE BACK BUTTON ON YOUR WEB BROWSER!

3. To reset your responses on a current page, use the RESET button at the bottom of the page.

4. Use the SAVE button to return to the assessment on the same computer at a later time.

5. Use the PRINT button (found on the last page of the assessment) to print the completed responses for the assessment.

6. When you have completed the assessment, click the SUBMIT button at the bottom of the last page to return your completed responses to DHS.

Q1 **Provider information**

Name of provider as enrolled with Minnesota Health Care Programs	
Provider NPI/UMPI (10 digit #)	
Name of foster care or SLS home	
Adult Foster Care license (put n/a if not applicable)	
CRS license (put n/a if not applicable)	
Street address of foster care or SLS home	
P.O. Box, if any	
City	
State	
Zip	
Taxonomy code for this day service location if there is more than one location for this NPI	
Provider FEIN	
Provider phone number associated with this NPI or UMPI as enrolled with Minnesota Health Care Programs	
Telephone number for the enrolled provider representative at this foster care or SLS home	

Q2   **Contact information for the person who provided information for this assessment**

First name

Last name

Title

Q3   **Frequency on site**

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Annually

Q4   **DHS should contact the following person with any follow up questions:**

First name

Last name

Title

Telephone number

Email address

Q5   **What services do you or are you enrolled and licensed to provide in this home? Check all that apply.**

- [ ] Adult Foster Care services (AFC)
- [ ] Child Foster Care services (CFC)
- [ ] Family Adult Day Services (FADS)
- [ ] Respite Care services
- [ ] Supported Living Services (SLS)

Q6   **Please answer each question about this home:**

	Yes	No
Are Adult Foster Care or Supported Living Services provided in a building that also provides licensed services as a hospital, nursing facility, Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID) or Institution for Mental Diseases (IMD)?	○	○
Are Adult Foster Care or Supported Living Services provided in a building, on the grounds of or immediately adjacent to a publicly owned or operated hospital, nursing facility, ICF/IID or IMD?	○	○

Q7   **Please answer each question about this home:**

	Yes	No
a. Does funding for this **housing** limit it to people with disabilities?	○	○
b. Does funding for this **housing** require that 80% of residents be seniors be at least 55 years of age or older?	○	○
c. Does funding for this **housing** require that 80% of residents be either seniors at least 55 years of age or older or people with disabilities?	○	○
d. Are there other residences within a 3 block radius of this home?	○	○

Q8   **What is the license capacity of this home under the following licenses? Enter zero (0) for none.**

Adult Foster Care
[   ]

245D-CRS (Community Residential Settings)
[   ]

Please answer each question about this home.

Q9 **Does funding for this housing limit it to people with disabilities?**

- ○ Yes
- ○ No

Q10 **Please indicate the proximity of the home to any of the following:**

	Within 5 blocks	Within 10 blocks	Within 2 miles	More than 2 miles
Bank	○	○	○	○
Doctors office/clinic	○	○	○	○
House of worship	○	○	○	○
Grocery store(s)	○	○	○	○
Public transportation	○	○	○	○
Restaurant(s)	○	○	○	○
Other retail businesses	○	○	○	○

Q11 **The following questions are about FOSTER CARE AND SUPPORTED LIVING SERVICES that are paid for by the Elderly, Community Alternatives for Disabled Individuals, Community Alternative Care, Developmental Disability or Brain Injury Waivers.**

Please check all licenses, registration or designations, that apply to services provided in this home:

- ☐ 245D- Mental health certification
- ☐ 245D program license-CRS (Community Residential Setting)
- ☐ Adult Foster Care license
- ☐ Assisted living (designation on housing with services registration)
- ☐ Child foster care license
- ☐ Housing with services establishment registration
- ☐ MDH home care license - Basic or Class B
- ☐ MDH home care license - Comprehensive, Class A or Class F
- ☐ Special care unit - Alzheimer's or related condition (designation on housing with services registration)

Q12 **How many people are receiving the following services? Enter zero (0) for none.**

Adult Foster Care (BI, CAC, CADI Waivers)

Adult Foster Care (EW Waiver)

Supported Living Services (DD Waiver)

Q13 **Please estimate the percentage of people currently served based on their primary disability or condition.**

	Do not currently serve	Less than 25%	Between 25% & 75%	Greater than 75%
Brain injuries	○	○	○	○
Chemical health conditions	○	○	○	○
Chronic health conditions	○	○	○	○
Dementias or memory losses	○	○	○	○
Developmental disabilities	○	○	○	○
HIV/AIDS	○	○	○	○
Mental illnesses	○	○	○	○
Physical disabilities (including but not limited to mobility challenges)	○	○	○	○
Other	○	○	○	○

left characters left. Briefly describe the primary disability or condition.

Answer the following questions for people receiving Adult Foster Care or Supported Living Services in this home.

Q14 **How many bedrooms are available for people receiving Adult Foster Care or Supported Living Services?**

[   ]

Q15 **For people receiving Adult Foster Care or Supported Living Services in this home.**

	Yes	No
a. Do you have policies supporting choice of roommates and document roommate preferences in the person's provider plan?	○	○
b. Does each person have a lock on their bedroom door and a key (or fob) to open it with only appropriate staff having keys unless specified in their plan?	○	○
c. Does each person have a key (or fob) to open the outside door of their home and/or apartment building unless specified in their plan?	○	○
d. Does each person have access to a telephone in a private area?	○	○
e. Do all bathrooms shared by more than one person have a lock unless specified in each person's plan?	○	○
f. Does each person have a place to secure their personal property with only appropriate staff or others having access?	○	○
g. Do your policies support each person having control of their own medications (with exception of Schedule II controlled substances) with minimally restrictive safeguards such as a locked medication administration device in their private bedroom unless specified in their plan?	○	○

Q16 The following question addresses unrestricted facility access. Please check if each facility feature is physically accessible and if the policy supports unrestricted use.

	Physically accessible	Policy supports unrestricted use	Feature does not exist
All common areas of the home	○	○	○
All common outdoor areas (i.e. decks, porches)	○	○	○
Common outdoor areas	○	○	○
Cooking appliance(i.e. stove or microwave oven)	○	○	○
Dining area	○	○	○
Laundry area with washer and dryer	○	○	○
Living area	○	○	○
Refrigerator with freezer for private food storage	○	○	○

Q17 **The following address person-centered choices required in the federal rules.**

Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following unless specified in a person's plan. Policies should explicitly address each area to assure a person's choice.

Each person:

	All currently implemented	All will be implemented by 1/1/17	Don't know
Is free to come and go from their home	○	○	○
Is free to move in and around the community	○	○	○
May close and lock their bedroom door	○	○	○
May have any visitors of their choice	○	○	○
May have visitors at any time	○	○	○

	All currently implemented	All will be implemented by 1/1/17	Don't know
Each person has choice of:			
Décor in their bedroom	○	○	○
Hair style and color	○	○	○
How often they participate in social/community activities	○	○	○
Possessions and personal furnishings within their bedroom	○	○	○
Types of community activities	○	○	○
Types of social activities	○	○	○
What personal clothing and accessories they wear on a daily basis	○	○	○
What they want to each within options available	○	○	○
When and how they bathe	○	○	○
When they go to bed and get up	○	○	○
When they eat	○	○	○
Where they eat (i.e. common dining area, kitchenette, living room)	○	○	○
Where, when and who provides their hair care	○	○	○
With whom they eat or to eat alone	○	○	○

Q18 **The following address a person's rights to personal privacy, security and respect.**

Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following unless specified in a person's plan. Policies should explicitly address each area, to assure a person's choice.

	All currently implemented	All will be implemented by 1/1/17	Don't know
All incidents of lost or stolen property are documented and investigated	○	○	○
Appointment schedules, medications lists and all other personal information is private. This means the information is not visible to other program participants or visitors in public areas	○	○	○
Each person has a place to secure their personal property	○	○	○
Staff treat each person with respect in interpersonal communications (e.g. people addressed by their proper or preferred name, staff use respectful tone when speaking to people	○	○	○
Type, amount and process for staff sharing of information assures the privacy and respect of each person	○	○	○
When a person needs assistance with personal care, it is provided in private	○	○	○

Q19 **During a typical week, what is the average frequency people interact with community members.**

Type of community interaction

	1 day per week	2 -3 days per week	4 or more days per week	Less than 1 day per week
On-site interaction with community members who are no staff or people receiving services(i.e. book club, cooking, lunch with kids)	○	○	○	○
Off-site (off of the grounds of day service site) community-based enrichment activities (recreational, social, cultural, volunteer	○	○	○	○
Skill development/maintenance (i.e. social skills, transportation, completing purchases)	○	○	○	○
Other	○	○	○	○

 left characters left. **Briefly describe a frequency of less than 1 day per week for on-site interaction.**

[ ]

 left characters left. **Briefly describe a frequency of less than 1 day per week for off-site interaction.**

[ ]

left characters left. Briefly describe a frequency of less than 1 day per week for skill development maintenance.

left characters left. Briefly describe Other type of community interaction.

Q20   **The following questions address a person's satisfaction with services/supports.**

	Yes	No
Do people know how and where to report dissatisfaction/concerns?	○	○
Do you have way to get feedback on overall satisfaction at least annually and maintain the documentation?	○	○
Do you have a way to document and address concerns or dissatisfaction people report formally or share informally with any of your staff?	○	○

After you have printed this assessment, click the SUBMIT button to complete the assessment process.

Please respond to this assessment by May 29, 2015.

Thank you for completing this assessment! We appreciate your assistance.